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Specific areas for review will be identified based on prior outlier experience. When it is determined that a significant number of errors identified for a hospital is attributable to one source, review efforts will be focused on the specific cause of the error. Intensified review will be discontinued when the error rate falls below the norm for a calendar quarter.

Providers continue to be notified of all pending adverse decisions before a final determination by the PRO. If intensified review is required, hospitals are notified in writing and provided with a list of the cases that met or exceeded the error rate threshold. When intensified review is no longer required, hospitals are notified in writing.

Hospitals with cases under review must submit all supporting data from the medical record to the PRO within 60 days of receipt of the outlier review notifications, or outlier payment will be recouped and forfeited.

Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

14. Payment for Transfers

a. Hospitals

When a Medicaid patient is transferred, the transferring hospital or unit is paid 100% of the average daily rate of that hospital's payment for each day the patient remained in that hospital or unit, up to 100% of the DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

b. Medicaid-Certified Substance Abuse and Psychiatric Units

When a patient is discharged to or from an acute care hospital and is admitted to or from a Medicaid-certified substance abuse or psychiatric unit, both the discharging and admitting hospitals receive 100% of the DRG payment.

c. Medicaid-Certified Physical Rehabilitation Units

When a patient requiring medically necessary physical rehabilitation services is discharged from an acute care hospital and admitted to a Medicaid-certified rehabilitation unit, payment is made to the unit by a per diem rate. The discharging acute care hospital will receive 100% of the DRG payment. When a patient is discharged from a physical rehabilitation unit to an acute care hospital, the acute care hospital receives 100% of the DRG payment.

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15. Recalibration of Iowa-Specific Weights and Recalculation of Base Amounts and Capital Cost Add-ons

Iowa-specific weights are computed by using UB-92 charge data submitted by providers from January 1, 1997, through December 31, 1998. The DRG weights are recalibrated every three years, based upon the most complete and current charge information. All hospital base amounts plus the capital cost add-ons are recalculated every three years, based upon the most current and complete cost reports available.

16. Groupings or Classification of Providers

No special groupings or classifications of providers are established under this reimbursement methodology except state-owned facilities, as described in Section 8, Calculation of Indirect Medical Education Rate.

17. Exceptions or Exemptions to the Rate-Setting Process

Exceptions to the rate-setting process will be made under the following circumstances:

a. New, Expanded or Terminated Services

Hospitals may offer new or expanded services or permanently terminate a service. This may include the purchase of capital assets requiring certificate of need approval.

Hospitals shall submit a budget or other financial and statistical information no later than 180 days before the effective date of the recalculation of the DRG rates. Budgets should be submitted following the completion of a project requiring the certificate of need or Section 1122 approval by the Iowa Department of Public Health according to rules at 641 Iowa Administrative Code, Chapters 201 and 202.

These budgets and related information are subject to desk review and field audit where deemed necessary. Upon completion of the audits, DRG rates may be adjusted as indicated.

Failure of a hospital to submit the required information timely will result in no rate increase associated with these assets or services when recalculation of base amounts and capital cost add-ons is performed. When the hospital files documentation in a timely manner, the new rate will be made effective at the time new rates are established.

b. Fraud and Abuse

In cases where fraud and abuse have been verified, the hospital's DRG payment rate will be adjusted. If the hospital's base-year payment rate is subsequently determined to have been based upon false or misleading information, an appropriate adjustment will be made to the base-year rate, and all resulting overpayments will be recouped.

If the hospital's DRG rate in any future period is determined to be changed based on false or misleading information, an appropriate adjustment will be made retroactive to the effective date of the rate change and all resulting overpayments will be recouped. The fiscal agent does this by subtracting the recoupment amount from payments to be made until the recovery is complete.

If, after the rate-setting process is completed, an error is discovered which materially affects the cost report data used to calculate the hospital's payment rate, the payment rate may be adjusted accordingly. This will be done if the error amounts to 5% or more of the hospital-specific, case-mix-adjusted cost per discharge.

The dollar amount of all such adjustments will be determined according to the facts in each case, using generally accepted accounting principles deemed permissible by the American Institute of Certified Public Accountants or Medicare principles of reimbursement.

18. Rate-Setting Processes for Out-of-State Hospitals

Reimbursement of out-of-state hospitals for the provision of care to Iowa Medicaid patients will be equal to either:

A. The Iowa statewide average cost per discharge plus the Iowa statewide average capital cost add-on in effect at time of the patient's discharge multiplied by the DRG weight; or

B. Blended base and capital rates calculated by using 80% of the hospital's submitted capital costs.

Hospitals that elect to receive payment based on the Iowa statewide average base and capital rates (Option A) may still qualify for disproportionate-share payments if the hospital qualifies within its home state using the calculation of the Medicaid inpatient utilization rate. Payment for disproportionate share will be according to the standards described in Section 29.

Hospitals choosing Option B must submit a Medicare cost report (HCFA 2552) no less that 120 days before rebasing, using data for Iowa Medicaid patients only. The provider will then receive a case-mix-adjusted blended base rate using hospital-specific Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount. Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using cost report data.

Hospitals that qualify for disproportionate-share payments based upon their home state's definition for the calculation of the Medicaid inpatient utilization rate are eligible to receive disproportionate-share payments from the Graduate Medical Education and Disproportionate Share Fund.

A hospital that qualifies for direct or indirect medical education payments under Medicare guidelines shall qualify for direct or indirect medical education payments from the Graduate Medical Education and Disproportionate Share Fund.

Hospitals that wish to submit a cost report for the purpose of receiving blended rates must do so during the triennial rebasing period or within 60 days of a patient's discharge. Hospitals that elect to submit cost reports must submit new reports on an annual basis, within 150 days of the close of a hospital's fiscal year.

When audited, finalized cost reports become available from the facility's intermediary, these reports should be submitted to the fiscal agent for the Iowa Medicaid program. The calculated rate will remain in effect for the remainder of the current rebasing period.

19. Payment for Medicaid-Certified Special Units

Medicaid certification of substance abuse, psychiatric and rehabilitation units is based on the Medicare reimbursement criteria for these units. The Department of Inspection and Appeals is responsible for Medicaid certification of these units for Iowa hospitals. Certification for reimbursement is done by the Iowa Medicaid fiscal agent. Without reimbursement certification, no physical rehabilitation, psychiatric or substance abuse units will receive reimbursement at the higher certified rates.

To become certified for reimbursement for either a physical rehabilitation unit or a psychiatric unit, the hospital must forward the Medicare PPS exemption notice to the Iowa Medicaid fiscal agent every fiscal year when it becomes available. Supplemental Form 2977, indicating all the various certified programs for which the hospital may become certified, must also accompany the other notices. This form is available from the fiscal agent as part of the enrollment process or on request.

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Hospitals that elect to receive reimbursement certification for substance abuse units must submit approved documentation of the Iowa substance abuse inspection to the Medicaid fiscal agent, plus additional documentation of the specific substance abuse programs available at the facility, staffing, facility information, treatment standards, and description of the population served by the facility. The Medicaid fiscal agent will initiate the proper reimbursement certification for the provider after review of those documentation submissions.

In Iowa neonatal units are certified using standards adopted by the Department of Public Health in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care.

Medicaid reimbursement certification will be retroactive to the first day of the month during which the application for certification is received by the Medicaid fiscal agent. Hospitals that have had certification prior to July 1, 1993, do not have to reapply for certification by Medicaid but must submit the appropriate PPS exemption notices as they become due and available.

An out-of-state hospital may receive certified unit status as a qualifying psychiatric unit when the unit is eligible for reimbursement under the Medicare prospective payment system. Out-of-state hospitals must submit a copy of the Medicare PPS exemption notice to the Iowa Medicaid fiscal agent in order to receive special certification and payment as a Medicaid-certified psychiatric unit.

Neonatal units are accepted as being certified when the hospital is inspected by the home state agency responsible for licensing, using standards set forth by the American Academy of Pediatrics for newborn care and that notice is forwarded to the Medicaid fiscal agent for reimbursement certification as a level II or level III neonatal unit.

In-state hospitals will be reimbursed for neonatal, psychiatric and substance abuse units at the level of certification for corresponding DRGs. There will be no retroactive payment adjustment made (to a certified higher level payment) when the hospital fails to make timely application for reimbursement certification.

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20. Patients Receiving Services at a Lower Level of Care and Appropriateness of Admission Criteria

Payment to acute hospitals for patients for whom the PRO has determined that a lower level of care is medically necessary is made as follows:

- For patients who are determined to require skilled nursing level of care, per diem payment is made in an amount equal to the sum of:
  - The direct care patient-day-weighted median for hospital-based Medicare-certified nursing facilities times 120 percent, plus
  - The non-direct care patient-day-weighted median for hospital-based Medicare-certified nursing facilities times 110 percent.
- For patients who are determined to require nursing facility level of care, per diem payment is made in an amount equal to the sum of:
  - The direct care patient-day-weighted median for non-state-owned nursing facilities times 120 percent, plus
  - The non-direct care patient-day-weighted median for non-state-owned nursing facilities times 110 percent.

Medicaid adopts most Medicare PRO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the PRO reviews Medicaid short-stay outliers and all Medicaid patients readmitted within seven days.

21. Provider Appeals

In accordance with 42 CFR 447.253(e), a provider of service who is dissatisfied with a rate determination may file a written appeal. This appeal must clearly state the nature of the appeal and be supported with all relevant data. The Department of Human Services (DHS) contracts with the Department of Inspections and Appeals (DIA) to hold appeal hearings. Based upon a proposed decision issued by DIA, DHS makes a decision regarding the appeal and advises the provider accordingly within a period of 120 days.

22. Cost Reporting

Each participating Medicare provider must file a HCFA-2552 Medicare Cost Report or a HCFA-accepted substitute. Supplemental information sheets are also furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the fiscal agent for Iowa within five months after the close of the provider's fiscal year.

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23. Audits

In accordance with 42 CFR 447.253(g), each participating hospital is subject to a periodic audit of its fiscal and statistical records. DHS has agreements for exchange of Medicare and Medicaid information with the following intermediaries in Iowa and surrounding areas:

Cahaba Government Benefits Administrator (Des Moines and Sioux City)
Mutual of Omaha (Omaha, Nebraska)
United Government Services (Milwaukee, Wisconsin)
Blue Cross and Blue Shield of Wisconsin (Madison, Wisconsin)
Riverbend Government Benefits Administrator (Chattanooga, Tennessee)

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24. Hospital-Based Physician Cost Component

Medicaid reimbursement regulations require split billing of all hospital professional services. The professional component of all such bills must be billed on the HCFA-1500 claim form. In accordance with 42 CFR 405.521(d)(2), there are certain circumstances when Medicare will allow a facility with an approved teaching program to combine these components when billing for services. If a provider has been approved by Medicare to bill in this manner, Iowa Medicaid also allows the provider to bill in this fashion.

25. Recovery of Overpayments

When it has been determined that an inpatient hospital provider has been overpaid, a notice of overpayment and request for refund is sent to the provider. The notice states that if the provider fails to submit a refund or an acceptable response to the notice within 30 days, the amount of the overpayment will be withheld from weekly payments to the provider.

26. Fixed Rate

New DRG rates are effective beginning October 1, 1999. Effective July 1, 2001, rates for hospital inpatient services are decreased 3% from the rates in effect on June 30, 2001.

27. Rate Adjustments for Hospital Mergers

When one or more hospitals merge to form a distinctly different legal entity, the base rate plus the capital cost add-on are revised to reflect this new entity. Financial information from the original cost reports and original rate calculations is added together and averaged to form the new rate for that entity.

28. Interim Payment for Long-Stay Patients

Normal DRG reimbursement is made upon the patient's discharge from the hospital. If a patient has an extremely long stay, partial reimbursement to the hospital may be requested. A hospital can request an interim payment if the patient has been hospitalized 120 days and is expected to remain hospitalized for a minimum of an additional 60 days. Payment to the hospital is calculated at the same rate as normal DRG payments.

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29. Graduate Medical Education and Disproportionate Share Fund

Payment is made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share directly from the Graduate Medical Education and Disproportionate Share Fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

a. Qualifying for Direct Medical Education

Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

b. Allocation to Fund for Direct Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for July 1, 2000, through June 30, 2001, is $8,314,810, subject to legislative appropriations, and for utilization increases described in Section 31.

A reduction of this amount will be made if a hospital fails to qualify for direct medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

c. Distribution to Qualifying Hospitals for Direct Medical Education

Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

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1. Multiply the total of all DRG weights for claims paid from July 1, 1999, through June 30, 2000, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights will be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights will be updated by a three-year period effective for payments from the fund for July of every third year.

d. Qualifying for Indirect Medical Education

Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

e. Allocation to Fund for Indirect Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for July 1, 2000, through June 30, 2001, is $14,599,413, subject to legislative appropriations, and for utilization increases described in Section 31.

A reduction of this amount will be made if a hospital fails to qualify for indirect medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

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f. Distribution to Qualifying Hospitals for Indirect Medical Education

Distribution of the amount in the fund for indirect medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 1999, through June 30, 2000, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights will be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights will be updated by a three-year period effective for payments from the fund for July of every third year.

g. Qualifying for Disproportionate Share

Hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent or when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate.

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of:

- 2½ percent, or
- The product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

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For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

Information contained in the hospital's available 1998 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's inpatient Medicaid utilization rate.

Additionally, a qualifying hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

h. Allocation to Fund for Disproportionate Share

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share related to inpatient services for July 1, 2000, through June 30, 2001, is $6,978,925, subject to legislative appropriations, and for utilization increases described in Section 31.

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i. Distribution to Qualifying Hospitals for Disproportionate Share

Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 1999, through June 30, 2000, for each qualifying hospital by each hospital's disproportionate share rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights will be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights will be updated by a three-year period effective for payments from the fund for July of every third year.

In compliance with Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and supplemental disproportionate share payments described in Section 30 cannot exceed the amount of the federal cap under Public Law 102-234.

30. Supplemental Indirect Medical Education and Supplemental Disproportionate Share

In addition to payments from the graduate medical education and disproportionate share fund, payment will be made to all hospitals qualifying for supplemental indirect medical education and supplemental disproportionate share payments. The requirements to receive supplemental payments, the amounts available, and the methodology used for determining payments are as follows:

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a. Qualifying for Supplemental Indirect Medical Education

Hospitals qualify for supplemental indirect medical education payments by receiving a direct medical education payment from Iowa Medicaid, qualifying for an indirect medical education payment from Medicare, being an Iowa state-owned hospital with more than 500 beds, and having eight or more separate and distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

b. Available Amount for Supplemental Indirect Medical Education

The total amount of funding that is available for supplemental indirect medical education for July 1, 2000, through June 30, 2001, is $24,834,207. Adjustments made to this amount are subject to increases allowed pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248).

c. Payments to Qualifying Hospitals for Supplemental Indirect Medical Education

Subject to the amount available, the amount to be distributed to each qualifying hospital for supplemental indirect medical education is determined by the following formula:

1. The statewide average case-mix adjusted operating cost per Medicaid discharge is multiplied by five and divided by two, then added to the statewide average capital costs multiplied by five and divided by two.

2. The resulting sum is then multiplied by the following:

$$\left[\frac{\text{(residents + interns)}}{\text{beds}}\right] \times 1.159$$

The number of interns, residents and beds is based on information contained in the hospital's base period Medicare cost report which will be updated when rebasing and recalibration are performed. Payments for supplemental indirect medical education will be on a monthly basis.

d. Qualifying for Supplemental Disproportionate Share

In-state hospitals that are state-owned acute-care hospitals, that have more than 500 beds, and that qualify for payments from the Graduate Medical Education and Disproportionate Share Fund for disproportionate share, also qualify for supplemental disproportionate share payments.

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e. Available Amount for Supplemental Disproportionate Share

To comply with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total amount of disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund and supplemental disproportionate share cannot exceed the amount of the federal cap under Public Law 102-234.

The amount available for supplemental disproportionate share payments will be the lessor of:

- The applicable state appropriation, or
- The federal cap minus disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund.

In compliance with Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234), the payments made for disproportionate share are not funded through a previously implemented taxation or donation program outlined under the above referenced law. As there is no tax or donation program used for this funding, any proposed disproportionate-share payments made to providers will not be reflective of taxes or contributions paid to the state of Iowa by that specific provider.

All disproportionate-share payments are funded through Iowa's customary "broad-based" taxation processes in current use, which are not thought to be subject to the restrictions outlined in this law.

Disproportionate-share payments made to hospitals will not exceed 12% of Iowa's overall expenditures for Medical Assistance, or the greater of

- The total disproportionate-share amount for the state, as calculated by the use of the 1923(c)(1) minimal for disproportionate-share hospitals (as provided for in 1923 (f)(2)(B)(ii) of the statute or
- The previous year's allotment cap multiplied by the state growth factor for the current year.

Total Medicaid and disproportionate share payments will not exceed the hospital-specific disproportionate share limits.

If the total calculation for disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund plus the supplemental disproportionate share payments results in more than the disproportionate share allotment, the payments will be reduced on a pro-rata basis, based on Medicaid discharges.

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f. Payments to Qualifying Hospitals for Supplemental Disproportionate Share

Payments for supplemental disproportionate share are made after the end of each federal fiscal year. Subject to the amount available, qualifying hospitals receive a payment of up to 166 percent of the hospital's total calculated reimbursement for all cases paid by the Medicaid fiscal agent within the previous federal fiscal year.

31. Allocation for Increased Utilization

The methodology to disburse payments to hospitals from the Graduate Medical Education and Disproportionate Share Fund does not include a utilization inflator. Money will be either positively or negatively allocated to the fund, when the average monthly Medicaid population deviates from the previous year's averages by greater than 5%.

The average annual population (expressed in a monthly total) is determined on June 30th for both the previous and current years by adding the total enrolled population for all respective months from both year's B-1 MARS report and dividing each year's totals by 12.

If the average monthly number of enrolled persons for the current year is found to vary more than 5% from the previous year, a PMPM amount will be calculated for each component (using the average number of eligibles calculated above), and an annualized PMPM adjustment will be made for each eligible person than is beyond the 5% variance.

32. Relationship to Managed Care

All monetary allocations made to fund the Graduate Medical Education and Disproportionate Share Fund for direct medical education, indirect medical education, and routine disproportionate share payment are reimbursed directly to hospitals. These payments have been deducted from all managed care capitation payments as part of the rate-setting methodology. No additional payments for these components will made to any managed care organizations.